

COLUMBUS HEALTH DEPARTMENT
240 Parsons Avenue, Columbus, Ohio 43215

AUTHORIZATION TO RELEASE INFORMATION

I, _____ (_____), _____,
Name: first middle last maiden name date of birth

am allowing Columbus Health Department (agency or person releasing information) to release the following
Information about my healthcare to: (agency receiving information)

☐ Columbus Public School District ☐ Franklin County School District ☐ Southwestern City Schools
☐ Worthington School District ☐ Other _____

Information to be released-Check all that apply:

☐ Mental health history ☐ Medical history ☐ Discharge notes ☐ Services notes
☐ HIV/AIDS/ARC history ☐ Billing ☐ Diagnosis ☐ Lab results
☐ Alcohol/Drug abuse history : **Immunization Information**
☐ Other _____

Information is to be released for the purpose(s) of - Check all that apply:

☐ Continuity of care ☐ Making a referral ☐ Informing referral source
☐ Reimbursement/benefits ☐ Legal :Other Required Immunization Updates

Amount of information to be released includes – Check one:

: All service dates ☐ Information from _____ through _____
date date

- **The Columbus Health Department MAY NOT deny treatment based on whether you sign this authorization.**
- **The information released could be further released and no longer protected by the Privacy regulations.**
- **I understand that I may cancel this authorization at any time by sending a written request to the Columbus Health Department. This request will not apply to information already released.**

This authorization will remain in effect for 60 days after the date I sign it unless another date or event is specified here: 5 Years after date of signature

Signature: _____ Date: _____

Relationship if other than self: ☐ Parent ☐ Guardian Witness: _____

I HEREBY CANCEL THE ABOVE AUTHORIZATION AS OF THIS DATE:

Signature: _____ Date: _____

Redisclosure of alcohol and drug abuse information: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987) 08/04/2003